CHAPTER 1
HEALTH SYSTEMS STRENGTHENING: AN INTRODUCTION

*A previous version of this chapter was prepared by the Partners for Health Reform*plus *Project as a Technical Reference Material module on* Health Systems Strengthening*, for the Child Survival and Health Grants Program, 2005.*

1.1 Introduction: Defining *Health Systems* and *Health System Strengthening*

At its broadest, health system strengthening (HSS) can be defined as any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency (Health Systems Action Network 2006).

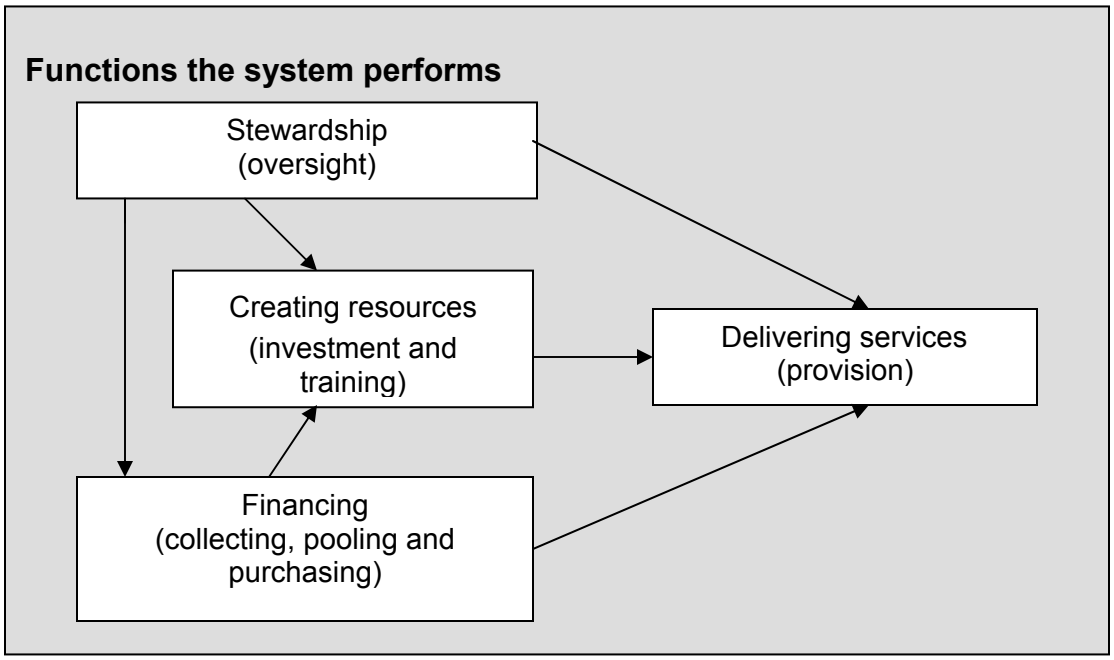
The purpose of this chapter on HSS is to—

- Provide U.S. Agency for International Development (USAID) Mission health teams and program implementers with a general overview of HSS
- Explain the relationship between efforts to improve the delivery of high impact services and overall HSS
- Suggest how USAID bilateral projects can benefit from HSS approaches to enhance project results and sustainability

The functions of the health system and the ways in which those systems can be strengthened are further detailed in the sections that follow. These issues are further discussed in Chapters 5–11 of this manual.

Health systems can be understood in many ways. The World Health Organization (WHO) defines health systems as "all the organizations, institutions, and resources that are devoted to producing health actions." This definition includes the full range of players engaged in the provision and financing of health services including the public, nonprofit, and for-profit private sectors, as well as international and bilateral donors, foundations, and voluntary organizations involved in funding or implementing health activities. Health systems encompass all levels: central, regional, district, community, and household. Health sector projects engage with all levels and elements of the health system and frequently encounter constraints that limit their effectiveness.

The *World Health Report 2000* (WHO 2000) identifies the four key functions of the health system: (1) stewardship (often referred to as *governance* or *oversight*), (2) financing, (3) human and physical resources, and (4) organization and management of service delivery. Figure 1.1 illustrates the relationship between the four functions of health systems.



Source: Adapted with permission from WHO (2001).

Figure 1.1 Functions the Health System Performs

1.2 Stewardship (Governance), Policy, and Advocacy

The stewardship, or governance, function reflects the fact that people entrust both their lives and their resources to the health system. The government in particular is called upon to play the role of a steward, because it spends revenues that people pay through taxes and social insurance, and because government makes many of the regulations that govern the operation of health services in other private and voluntary transactions (WHO 2000).

The government exercises its stewardship function by developing, implementing, and enforcing policies that affect the other health system functions. WHO has recommended that one of the primary roles of a Ministry of Health is to develop health sector policy, with the aims of improving health system performance and promoting the health of the people (WHO 2000). Governments have a variety of so-called policy levers they exercise to affect health programs and health outcomes (Table 1.1).

Table 1.1 Government Policy and Health Programs

Governmental Policy Levers	Relevance to Health Programs
Size of the total government health budget	Sets the overall limit on what a government can spend
Financing mechanisms for funding the health care system (e.g., donor support, taxes, user fees, social insurance contributions)	Determine what flexibility the government has for financing health care and identify potential financial barriers that may exist for accessing care (e.g., fees, their levels, and exemptions)
Allocation of the government health budget	Reflects how the government uses its tax resources to, for example, deliver services, employ staff, subsidize providers, regulate the sector, provide information, and configure the sector in terms of preventive vs. curative services, personnel vs. supplies, investment in human resources (training) vs. physical resources (hospital) Affects which programs are prioritized and what populations will benefit (rich vs. poor, urban vs. rural)
Regulation of civil society organizations	Can facilitate or constrain the functioning of private voluntary organizations (PVOs), nongovernmental organizations (NGOs), and community organizations with regard to service delivery and the capacity such groups have to influence and advocate for health services
Political support to raise awareness for specific health messages and behaviors (e.g., clear government support for specific health messages such as prevention of HIV, contraceptive use, or TB treatment)	Can be powerful for stigmatized or polemic health initiatives and promoting high impact health interventions (e.g., hand washing)
Adoption of specific health standards or guidelines	Can improve the quality of care, expand or constrain the number of providers, and facilitate implementation of approaches such as Integrated Management of Childhood Illness (IMCI).
Regulation of pharmaceuticals	Can improve medicine quality assurance and rational use of medicines Can influence the ability to bring medicines and supplies into the country
Business regulations and taxation	Can influence the degree to which the private sector participates in health care—for example, import taxes can affect pharmaceutical sales; business regulations can hamper private providers from setting up practices; limitations on advertising can limit promotion of branded health products

An example of strong government stewardship in health can be found in Uganda, where the government's proactive approach to preventing HIV/AIDS is likely to have reduced the incidence of the disease. The government provided an enabling environment by encouraging community-based initiatives and supporting mass communication campaigns, which promoted prevention and behavior change.

Furthermore, stewardship in health encompasses (1) activities that go beyond the health system to influence the main determinants of health (e.g., education, poverty, environment), and (2) other issues that are external to the health system, but which either foster or constrain its effectiveness. For example, a government may decide to tax imported medicines to increase general tax revenues or to protect local producers, but in doing so, will increase prices to consumers and impair access to these medicines. Stewardship in this area seeks to influence the broader environment in which the health system operates.

Emerging research evidence demonstrates that health is a key component to good development policy (Saunders 2004). The presence of poor health conditions in a country slows economic growth directly as societies lose potential workers and consumers to disease and disability. Attention to reducing child mortality and morbidity results in healthier children who can attend school and eventually contribute to economic growth when they become wage-earners. When child survival is the norm, parents tend to have fewer children and are able to invest more in their children's education and health.

Priorities in health policy also need to be elaborated at the national and local levels through health goals that address improving the health of the poor and reducing the gap between the poor and non-poor for an impact on child survival (Gwatkin 2000). Although the establishment of policy lays an essential foundation for a government's intention, its value depends on the evidence and effects of policy implementation.

As such, health system assessment should take account of the degree of government decentralization and the levels and authorities that are the key decision makers in health. Which levels have authority over planning, budgeting, human resources, and capital investment? Is the health sector represented at the district council level? Does the district have a role in policy development, resource allocation, and human resource planning? These dimensions underscore the need to approach health system performance and strengthening by understanding the interaction and linkages that exist between health financing, service delivery, and management of human resources in the health sector.

1.2.1 Performance Criteria

Understanding the health policies of the national government, and its international commitments, allows for informed development of advocacy for improved health care ***access, equity,*** and ***quality***. In addition, national policies affect the system's ability to deliver ***efficiency***, thereby affecting the overall ***sustainability*** of the system and its ability to function into the foreseeable future from a financial and organizational perspective. These performance criteria are defined and further explained in Annex 1A.

1.2.2 Sustainability

A stronger health system is fundamental to sustaining health outcomes achieved by the health system. Sustainability typically cannot be guaranteed through changes at the local level only. For example, health providers can be trained at the local level, but if these providers cannot be

retained or supervised or if medicines and supplies are not available, then health gains will be limited.

Sustainability of health programs can be addressed on several levels: institutional, program, community, and health outcomes. Below in Table 1.2 are some examples of how each level of sustainability defined for child survival can be linked to the broader health system to contribute to sustainability.

Table 1.2 Linking Priority Health Services Sustainability in the Health System

Level of Sustainability	Health System
Institutional	Ensures legal framework is in place to facilitate establishment and sustainability of private organizations Develops sustainable management and financing systems within organizations
Programmatic	Seeks consistency between priority health services and broader health information systems (HIS), quality standards, and other elements Shares programmatic successes with health officials and policymakers for broader application in the health system
Community	Broadens community involvement to include advocacy for policies that support sustainability of priority health services
Health outcome	Ensures— • Strong government stewardship • Pro-low-income health policies • Political leadership to promote community and household actions that, in turn, promote priority health services • Adequate health financing for services and resources • A provider payment system that rewards delivery of primary care • Effective licensing of professional providers • A functioning pharmaceutical and commodity supply system • A functioning HIS that tracks priority health services indicators

1.3 Health Financing

1.3.1 Why Health Financing Is Important

Health financing is a key determinant of health system performance in terms of equity, efficiency, and quality. Health financing encompasses resource mobilization, allocation, and distribution at all levels (national to local), including how providers are paid. Health financing refers to "the methods used to mobilize the resources that support basic public health programs, provide access to basic health services, and configure health service delivery systems" (Schieber and Akiko 1997). Understanding health financing can help answer questions such as the following—

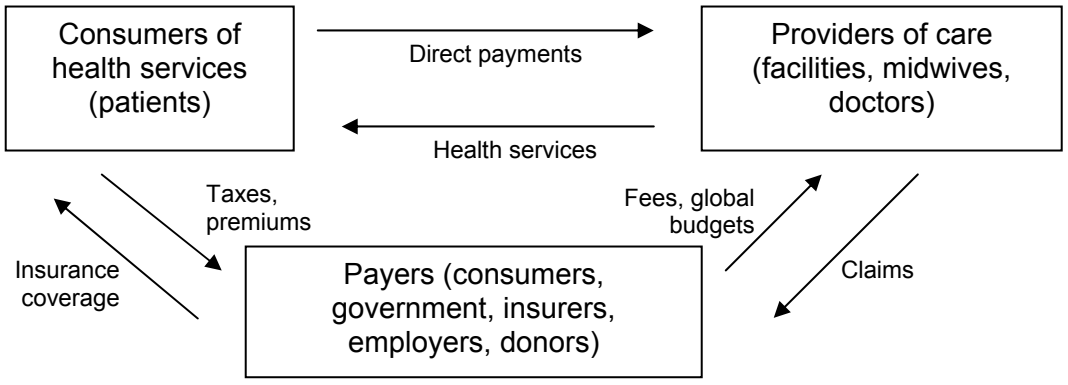
- Are resource mobilization mechanisms equitable? Do the wealthier subsidize the poor and those most in need?
- Is the distribution of resources equitable? Efficient? Or are wealthier populations benefiting more from public financing than are poorer populations?
- Do provider payments reward efficiency? Quality?

By understanding how the government health system and services are financed, programs and resources can be better directed to strategically complement the health financing already in place, advocate for financing of needed health priorities, and aid populations to access available resources.

Many health sector programs are involved in strengthening health financing systems by mobilizing resources, advocating how resources should be allocated, and configuring health service delivery. Some examples of successful health financing interventions with impact on priority services are found in Annex 1B

1.3.2 The Health Financing System

The health financing system consists of the payers, providers, and consumers of health services and the policies and regulations that govern their behavior (see Figure 1.2). The simplest example is when the patient pays the provider directly, whereby the consumer and payer are the same person.



Source: Adapted from Schieber and Akiko (1997).

Figure 1.2 Financing Flows in the Health System

1.3.3 Sources of Health Financing

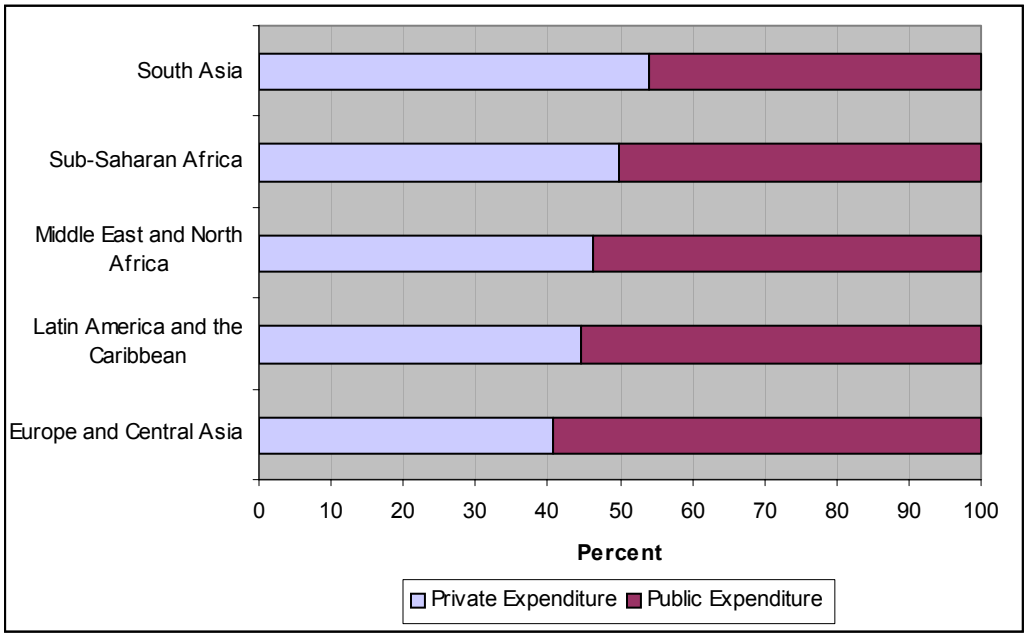
Health systems in developing countries are financed through a mix of public, private, and donor sources. The mix of sources varies widely.

Public sources are governments that raise funds through taxes, fees, donor grants, and loans (Schieber and Akiko 1997). Typically the Ministry of Finance allocates general tax revenue to finance the Ministry of Health budget. Most government health budgets are historical; that is, they are based on budgets from previous years that are adjusted annually to account for inflation or at the same rate as most other government spending. These budgets usually have separate line items for personnel, hospitals, pharmaceuticals, supplies, fuel, and training, and they finance only recurrent costs. Capital investments are often found in a separate budget that may be paid for through donor grants or loans.

In decentralized health systems, district health authorities are often given power to allocate nonpersonnel, noncapital investment funds at the local level to social sector budgets such as education and health. This flexibility allows for some local priority-setting according to needs within social sectors. A few countries use global health budgets that give recipients (e.g., district health authority or hospital) discretion over how to allocate the budget.

Private sources include households and employers who pay fees directly to providers in both public and private sectors, pay insurance premiums (including payroll taxes for social health insurance), and pay into medical savings accounts and to charitable organizations that provide health services. Household out-of-pocket payments form a large source of health financing in many developing countries (Zellner, O'Hanlon, and Chandani 2005).

The private sector is an important source of health financing in most developing countries. Figure 1.3 shows that private expenditure on health is large compared with public expenditure in all regions. Private expenditure is primarily in the form of out-of-pocket expenditures by households (WHO 2006).



Source: WHO (2006) data

Figure 1.3 Percentage Expenditure on Health—Private versus Public

Reliance on user charge financing at the point of service puts a greater burden of ill health on poorer households. In the case of catastrophic health events, the need to pay can impoverish families or cause them to forego treatment.

Out-of-pocket payment in the public sector is a common means of public financing for health (Schieber and Akiko 1997). A user fee is a type of **cost sharing** for public programs. In addition to resource mobilization, user fees can prevent excessive use of services. In Zambia, the government shares the cost of health services with the population through user fees, and the funds retained are usually used at the local level to supplement staff salaries or purchase supplies.

To promote equity, countries implementing user fees usually have an **exemption** policy for certain groups of individuals or circumstances. Exemptions usually target specific services and populations, such as immunizations or children under five. Significant challenges can arise in applying an exemption policy on a consistent basis, as is illustrated in Table 1.3, because of varying practices and policies in a decentralized system and difficulties in verifying income status of individuals and households.

Table 1.3 Health Centers Reporting Fee Exemption Practices in Three Regions in Ethiopia (percentages)

Exempted Service	Amhara	Oromia	Southern Nations, Nationalities, and Peoples
Immunization	100	100	100
Prenatal care	94	100	95
Family planning	89	100	86
Delivery	50	67	71
HIV services	28	20	52
Malaria treatment	0	67	5

Note: The table illustrates the percentage of surveyed health centers that exempt fees for priority services. *Source:* Excerpted from John Snow, Inc (2005).

Fee waivers are another form of exemption whereby selected groups, such as civil servants, war veterans, or the verifiably poor, are exempted from payment. Many countries have attempted to define eligible groups according to poverty indicators, but ensuring equity in implementation is generally difficult (John Snow, Inc. 2005).

Donors finance health systems through grants, loans, and in-kind contributions. PVOs often are financed by donors and voluntary contributions. The **sector-wide approach** (SWAp) is a financing framework through which government and donors support a common policy and expenditure program under government leadership for the entire sector. A SWAp implies adopting common approaches across the sector and progressing toward reliance on government procedures and systems to disburse and account for all funds. Many countries with SWAp mechanisms have a diversified funding mix, including grant-funded projects.

Under the SWAp, **basket funding**—a common funding pool to which SWAp partners contribute—enables flexibility in allocating funds according to government priorities and programs. This approach differs from project financing and vertical programs, in which funds are provided for a specific purpose and may be managed independently of the government budget or priorities. Another means by which donors can commit funds to government health programs is through **budget support**. These grants or loan contributions to the general treasury can have particular earmarks for sectors, such as health and education, and can be used for purposes identified by the relevant ministries.

1.3.4 Health Insurance Systems and Mechanisms

Health insurance is a system whereby companies, groups, or individuals pay premiums to an insurance entity to cover medical costs incurred by subscribers. Depending on how an insurance system is structured, it can pool the premium payments from the rich and healthy with the poor and sick to improve equity and thus prevent impoverishment by covering medical costs from catastrophic illness or injury. Health insurance does not create new funds for health and can increase inequities (e.g., if members are mainly the better-off).

In the public sector, **social health insurance** (SHI) programs are set up as mandatory insurance systems for workers in the formal sector. SHI contributions, which are typically payroll taxes from both employers and employees, are placed in an independent or quasi-independent fund separate from other government finances. SHI contributions may improve equity by mandating larger contributions from higher paid workers (Normand 1999). SHI has been successful in Organisation for Economic Co-operation and Development countries, which have a large and robust formal sector. Thailand, some of the Eastern European countries and former Soviet republics, and many countries in Latin America have well-functioning SHI systems. SHI systems in countries such as Morocco, Egypt, and Mexico cover substantial populations in which a household member works in the formal sector; however, the majority of the population in each country is not covered, including the poorest. SHI systems in low-income countries generally lack the resources to provide wide coverage of quality health services, although some SHI systems have their own facilities or contract with NGOs and commercial providers to expand access.

Whereas social insurance primarily pools risk across income groups, **private insurance** is based on the distribution of risk between the sick and the well (Normand 1999). Private insurance is quickly growing in developing countries as the private sector in many regions expands and employers seek ways to provide health insurance to their employees. Unlike social insurance, private insurance is often “risk-rated,” meaning that those who are judged more likely to need care pay a higher insurance premium. This arrangement often limits those covered by private insurance to employees—who as a group are lower risk—and benefits do not reach lower income populations and those in the informal sector.

Box 1.1
CBHF Schemes vs. Conventional Health Insurance

"CBHF schemes share the goal of finding ways for communities to meet their health financing needs through pooled revenue collection and resource allocation decisions made by the community. However, unlike many insurance schemes, CBHF schemes are typically based on the concepts of mutual aid and social solidarity" (Bennett, Gamble Kelley, and Silvers 2004).

Both private insurance and SHI mainly cover those working in the formal sector, whereas **community-based health financing** (CBHF) reaches those in both the formal and informal sector, often in rural agricultural communities (Box 1.1). CBHF schemes, or mutual health organizations as they are known in West Africa, are community- and employment-based groupings that have grown progressively in several regions of Africa in recent years (Atim and others 1998). Through CBHF schemes, communities contribute resources to a common pool to pay for members' health services, such as user fees at a government facility or medical bills from a private health facility. Most CBHF schemes have a designated list of benefits, some focusing on primary health care, whereas others shield members from the catastrophic costs of hospitalizations.

In Rwanda, CBHF schemes have resulted in better access to quality health services for scheme members, resulting in a high level of membership (Butera 2004). Some schemes generate surpluses, which are sometimes used to subsidize premium contributions for the poorest households in the community, contributing to financial equity.

1.3.5 Provider Payments

An important goal of the health system is to assure the right incentives for providers. Provider payments are categorized as either prospective or retrospective. Prospective payments are a set amount established before services are provided, such as capitated or case-based payments (Barnum, Kutzin, and Saxenian 1995). Retrospective payments, typically referred to as fee-for-service payments, are made after the services have been provided.

How providers are paid affects their behavior. The payment mechanism can promote or discourage efficiency; affect quality, supply and mix of providers, and supply and mix of services; and determine which patients receive care. The main types of provider payment mechanisms are salaries, fee-for-service, capitated payment (a fixed amount per person, which is the way health maintenance organization providers are paid), and case-based payment (fixed amount per diagnosis, such as the Diagnosis-Related Groups, or DRG systems, used by Medicare). The provider payment system can include incentives for provision of child health and other essential services.

A lesson learned from health financing reform is the value of experimentation with different payment methods to achieve optimal methods for local conditions. Testing reforms in local demonstration sites to determine impact allows policymakers to make corrections before launching national-level reforms (Wouters 1998).

1.4 Human and Physical Resources

The third function of the health system is the recruitment, training, deployment, and retention of qualified human resources; the procurement, allocation, and distribution of essential medicines and supplies; and investment in physical health infrastructure (e.g., facilities, equipment).

The human resources interventions in Table 1.4 illustrate the link between common human resources problems—such as maldistribution, poor motivation, and poor capacity—and higher level system issues.

Table 1.4 HSS for Human Resources

Human Resource Issues	Possible National-Level HSS Interventions
Production of right number and mix of health workers by medical, nursing, and allied health schools	Long-term planning and coordination with Ministry of Education to, for example, promote training of more primary care physicians and fewer specialists
Management and supervision for quality assurance, worker motivation, and production and use of health information	Organizational development at the Ministry of Health, job descriptions and worker performance systems to increase accountability, and links to training and improved health outcomes Civil service reform to allow reform of provider payment systems Coordinating with and strengthening professional regulatory bodies to build support for and reinforce interventions in, for example, compensation and training
Compensation, including provider payments and benefits, to improve retention and performance	Provider payments that reward quality and productivity or reward deployment to specific geographic areas Integration of compensation for community health workers
Continuing education and training for public, private sector, and community health workers	Investment in health training institutions Integration of child health training curricula into local medical and nursing schools Linking training to job roles, supervision, and compensation to ensure that new skills are applied and reinforced, and to licensing or accreditation standards
Ensuring the availability of medicines, supplies, equipment, and facilities so health workers can perform	Financing reforms to increase financing of essential medicines, supplies, and equipment Donor coordination and sector-wide planning for investments in facilities Strengthening of procurement and logistics systems

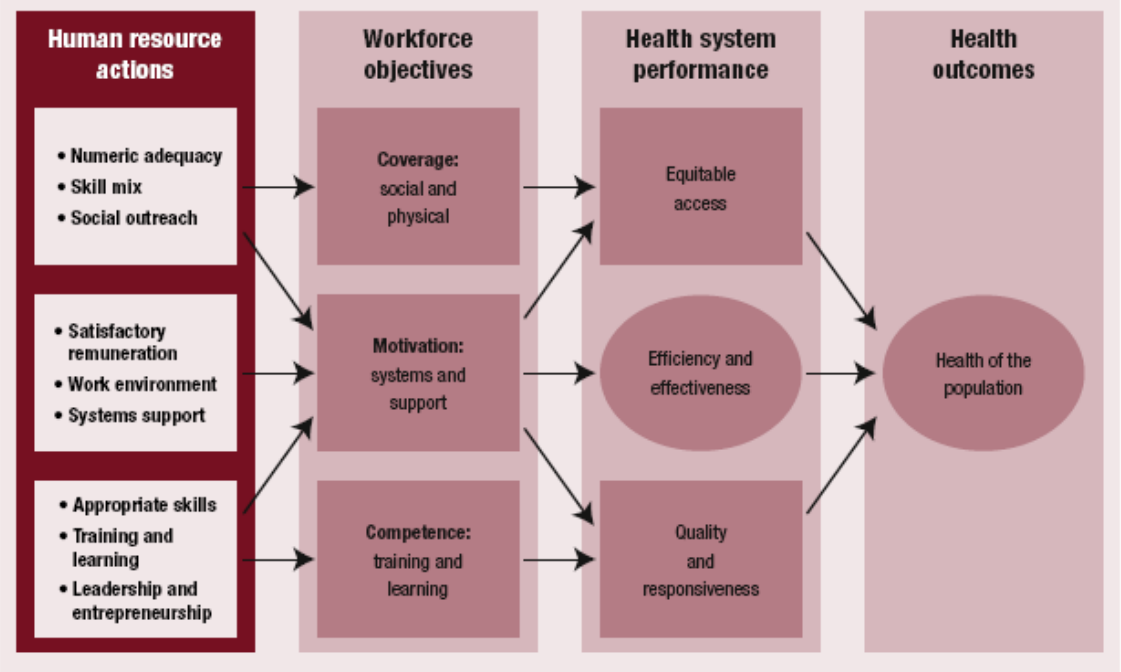
1.4.1 Human Resource Management in the Health Sector

WHO notes that human resources are the most important part of a functional health system (WHO 2000). Recently, attention has focused on the fact that progress toward health-related Millennium Development Goals (MDGs) is seriously impeded by a lack of human resources in health, with serious implications for child survival and health goals. In many cases, PVOs and

their service providers are filling the gaps left by insufficient public health workers, inaccessible private health providers, or both.

For government health workers, evidence shows that effective public management can contribute to improved performance of workers. New public sector management philosophy calls for responsibilities to be delegated to local areas with responsibility for specific tasks and decision making at the local level, a focus on performance (outputs and outcomes), a client orientation, and rewards or incentives for good performance (World Bank 2004).

As illustrated in Figure 1.4, the appropriate training, distribution, and support of health care workers has multiple management, technical, and resource dimensions. A key human resources challenge concerns compensation for health workers. Government or local remuneration norms are often too low to motivate workers, and policy to guide international agencies to apply standardized rates is often lacking.



Source: Joint Learning Initiative (2004, p. 5).

Figure 1.4 Managing for Performance

Key human resources issues and their impact on the system (Joint Learning Initiative 2004) include the following—

- *Low, and possibly declining, levels of medical human resources.* In many developing countries, medical education programs are not producing enough doctors and other health workers. This deficit is compounded by the outflow of trained staff from the public sector to the private sector and from developing countries to industrialized countries and, particularly in Africa, by the loss of health workers to HIV/AIDS.

- *Geographic imbalances.* Urban areas have higher concentrations of trained health care personnel than rural areas; incentives to work in remote areas are lacking.

- *Imbalance of skills' mix and poor skills.* Unskilled staff provide services for which they are unprepared. Training is often poor, and little or no training to update skills is available. As a result, mistreatment and misdiagnosis can be commonplace.

- *High degree of absenteeism.* Related to inadequate compensation and supervision, civil service laws or cultural obstacles preclude terminating staff who do not perform well.

Appropriate solutions to these issues are affected by a wide range of related problems, including the lack of public funds for health programs, inadequate training facilities, and competing regional efforts for health workers.

1.4.2 Medicines, Supplies, and Logistics Systems

Access to essential medicines and supplies is fundamental to the good performance of the health care delivery system. Availability of medicines is commonly cited as the most important element of quality by health care consumers, and the absence of medicines is a key factor in the underuse of government health services.

WHO estimates that one-third of the world's population lacks access to essential medicines. Problems in access are often related to inefficiencies in the pharmaceutical supply management system, such as inappropriate selection, poor distribution, deterioration, expiry, and irrational use. Where medicines are available, price may be a barrier for the poor. Pharmaceutical subsidies, fee waivers, and availability of affordable generic medicines are some of the pharmaceutical financing approaches that can mitigate barriers to access.

Weak regulation of the pharmaceutical market is associated with poor quality control, presence of fake and substandard medicines on the market, growing drug resistance problems due to irrational use, dispensing by unqualified practitioners, and self-medication in lieu of seeking qualified health care.

Improved pharmaceutical supply management is an element of many health sector reform efforts. Promising improvements in pharmaceutical supply systems have been made in some countries; however, many continue to struggle with a mix of inefficient public sector and private supply systems. Decentralization of health sectors has in some cases intensified the problem, establishing logistics systems in the absence of trained human resources, infrastructure, and management systems at the decentralized levels. Where more efficient systems have been established, countrywide access may still remain weak.

1.5 Organization and Management of Service Delivery

This health system function includes a broad array of health sector components, including the role of the private sector, government contracting of services, decentralization, quality assurance, and sustainability. This section is not intended to be all-inclusive but rather to briefly describe

some of the key organizational and managerial components of the health system that can directly or indirectly affect health service delivery. For a brief description of how government policy and regulation affect the organization and management of service delivery, see Section 1.1.

1.5.1 Decentralization

Governments pursue decentralization to improve administrative and service delivery effectiveness, increase local participation and autonomy, redistribute power, and reduce ethnic and regional tensions; decentralization is also used as a means of increasing cost efficiency, giving local units greater control over resources and revenues, and increasing accountability (Brinkerhoff and Leighton 2002).

Decentralization deals with the allocation of political, economic, fiscal, and administrative authority and responsibility from the center to the periphery. Most experts agree that there are several types of decentralization (Rondinelli 1990)—

- *De-concentration:* the transfer of authority and responsibility from the central office to field offices of the same agency
- *Delegation:* the transfer of authority and responsibility from central agencies to organizations outside their direct control, for example, to semiautonomous entities, NGOs, and regional or local governments
- *Devolution:* the transfer of authority and responsibility from central government agencies to lower level autonomous units of government through statutory or constitutional measures
- *Privatization:* sometimes considered a separate type of decentralization

Health sector programmers should be prepared to take advantage of the opportunities that decentralization presents and be aware of the constraints it may impose, in whichever stage of decentralization the country is in. (See Table 1.5)

Table 1.5 Decentralization Opportunities and Constraints and Implementation Issues

Opportunities	Constraints and Implementation Issues
• Greater citizen participation to identify health needs and decide how to use health resources • Increased equity, solidarity, efficiency, and self-management • More efficient use of public resources • Better and faster response to local demands • Improved accountability and transparency • Public-private collaboration at the local level • Increased health worker motivation	• Delegation of responsibility without delegation of authority or adequate resources • Lack of capacity at the decentralized levels • Lack of political support at the central level • Lack of clarity regarding new roles • Disruption of existing systems such as the health information system and pharmaceutical supply • Disruption of public health programs such as immunization • Loss of federal employment benefits when workers shift to subnational level

In practice, decentralization efforts have had mixed results. HSS seeks to assist countries to implement decentralization more effectively by—

- Clarifying new roles
- Aligning resource allocation with responsibility
- Building capacity at decentralized levels so staff can absorb new responsibilities
- Building capacity at the central level in its new role of policy formulation, regulation, and performance monitoring

1.5.2 Private Sector

The private sector is a key source of health services, and its coverage is rapidly increasing. (See Box 1.2) Use of government health services is too low to affect indicators such as child mortality without the contributions of private sector health services, including NGO services (WHO 2003). Information from the Multi-Country Evaluation of Integrated Management of Childhood Illness has shown that IMCI must be adopted by private sector health services, in addition to government health services, to achieve a reduction in child mortality in some countries.

The private health sector is typically defined to comprise "all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease" (Mills and others 2002). Private sector actors include the following—

- Private providers including for-profit (commercial) and nonprofit formal health care providers (private hospitals, health centers, and clinics) and traditional and informal practitioners, including traditional midwives and healers
- Community-based organizations and civil society groups that do not directly provide health services, but provide complementary or related services such as advocacy groups, voluntary support groups, and community-based health insurance schemes
- Wholesalers and retailers of health or health-related commodities such as medicines, oral rehydration solution (ORS), insecticide-treated nets, and contraceptive supplies; retailers may range from pharmacies with qualified

Box 1.2
Evidence of the Role of the Private Sector

Review of *Demographic and Health Survey* data from 38 countries shows that 34 to 96 percent of children in the poorest income quintile who seek treatment for diarrhea, and 37 to 99 percent of children who seek care for acute respiratory tract infection receive that care in the private sector.

In India, the private sector distributes 65 to 70 percent of the oral rehydration solution used in the country.

In sub-Saharan Africa, the majority of malaria episodes are initially treated by private providers, mainly through the purchase of medicines from shops and peddlers.

Source: Bustreo and others (2003)

pharmacists to small unregulated medicine stalls in the private sector and general retailers who carry health-related products

- Private companies that take actions to protect or promote the health of their employees (such as company clinics or health education programs)
- Private health insurance companies that offer insurance and can also influence provider incentives via their contracting and payment mechanisms

Annex 1C summarizes the variety of types of interventions that have been used to engage the private sector in the delivery of health products and services.

The following strategies could be used for health sector organizations to work with the private sector—

- Extending services in critical areas such as HIV/AIDS care through private health workers and providing clinical updates and training in management skills
- Engaging in contracting arrangements to supplement government service provision
- Social marketing of products for health improvement, such as condoms, ORS, insecticide-treated bed nets, and micronutrients
- Working with employer-based services to extend and improve priority services
- Informing or educating private providers about effective health service approaches such as IMCI (Waters, Hatt, and Peters 2003)

1.5.3 Contracting

Contracting of health services is an instrument by which governments can take advantage of private sector resources in the health sector. *Contracting* refers to any public purchasing or donor financing of services from private providers, both for-profit and nonprofit, and encompasses a broad spectrum of services. These services include, among others, the direct provision of health care, the training of health providers, management services, and the education of communities and households.

Governments in the developing world are increasingly contracting with NGOs either to deliver government-financed primary health care or to support government delivery of such care. This practice rests on the premise that the traditional organizational form of the public sector, with its hierarchical bureaucracy, has low and limited efficiency, and that the introduction of private management and support can enhance the efficiency of public spending on these services. Another rationale is that NGOs are often located in remote areas and capable of increasing access to and improving the quality of basic health services through their greater flexibility in management and their higher accountability.

The evidence of the impact of contracting on access, quality, equity, and health status is limited, however. A recent review by Liu and others (2004) identifies only 17 journal entries related to

the issue of contracting out primary health care services in developing countries. Overall, the existing literature highlights the need for extensive additional research on the effects of contracting of primary health care services on access, quality, and efficiency.

1.5.4 Quality Assurance

Quality assurance is a health system element that has grown in importance as costs of care have escalated and consumer awareness and demand for quality services have increased. Many studies demonstrate that use of services and willingness to pay are strongly related to patient perceptions of quality. Improved health outcomes are closely linked to quality improvements. Quality functions and institutions are found in various parts of the health system, for example, professional licensing, hospital and health facility accreditation, infection control committees, supervisory structures, national policy and standards committees, quality assurance committees within clinical services at various levels, and drug quality assurance authorities. Quality improvement processes may be at work in many areas of the system, via a wide range of instruments: standard treatment guidelines, in-service training programs, management quality assurance processes, medical records audit, health facility inspection, and peer review systems, among others.

1.6 Health Information Systems

HIS form an essential part of the larger body of health management information systems, the elements of which have a common purpose—to inform and guide decision making. Lack of capacity and progress in measurement and analysis of health information are well-known constraints to national policy making and resource allocation. HIS in many countries suffer from poor management and insufficient resources. At the facility level, health workers commonly spend 40 percent or more of their time filling in HIS forms (Bertrand, Echols, and Husein 1988) but may make little use of the data for decision making. HIS are beset with demands for change and expansion to meet the requirements of new programs and projects, often in the absence of a national policy and planning for this vital component of the health system.

Health management information supports decision making at various levels of the system, from central-level policy development to local monitoring of primary health care activities. Although data tend to move to higher levels in the system for compilation and analysis, use of the data for management at the district, facility, and community level is critical.

For the HIS to function adequately, certain prerequisites need to be in place, such as the following—

- *Information policies:* in reference to the existing legislative and regulatory framework for public and private providers; use of standards
- *Financial resources:* investment in the processes for the production of health information (collection of data, collation, analysis, dissemination, and use)
- *Human resources:* adequately trained personnel at different levels of government

- *Communication infrastructure:* infrastructure and policies for transfer, management, and storage of information

- *Coordination and leadership:* mechanisms to effectively lead the HIS

A functioning HIS should provide a series of indicators that relate to the determinants of health (i.e., socioeconomic, environmental, behavioral, and genetic determinants or risk factors) of the health system, including the inputs used in the production of health and the health status of the population. Such a list of indicators should be defined by the users of information at different level in a consensus-building process.

The HIS structure and functional format reflects the organizational structure of the health system and functions and the degree of decentralization at its various levels. Having a clear understanding of the overall, big-picture organization of the health care system is thus critical, as is an understanding of the division of responsibilities among the different levels which, in many countries, are (1) national or ministry level, (2) regional or provincial level, (3) district level, and (4) the health center or facility. The role of the private sector and its participation in the HIS should also be understood in advance as well as the role of other ministries.

1.7 HSS Strategies and Implications

In sum, projects that aim to expand and improve service delivery risk limiting their impact if they do not take into consideration the health system in which the services operate. In fact, HSS issues should be addressed at the pre-project assessment stage and remain in focus throughout project design and implementation.[1] When systems issues are not addressed, service delivery programs often fall short of their potential. For example, a family planning program may train volunteers in counseling, referral, and resupply of contraceptives, but if the system for commodity supply is weak, poor service outcomes and dissatisfied clients will likely be the results. In other words, the investment in mobilizing and training family planning volunteers will not, on its own, necessarily result in a successful family planning program.

Evidence from recent studies of child survival programs shows that health system constraints (such as high staff turnover, low quality training of health workers, poor supervision, lack of continuous supplies of pharmaceuticals and vaccines) are major impediments to increasing coverage of child health services (Bryce and others 2003). Health programs may be able to increase and sustain their impact by contributing to broader health system interventions through assessing, testing, and demonstrating system strengthening approaches. Table 1.6 provides some examples of system strengthening approaches to a sample of constraints typically faced by health programs.

[1] HSS may be a lesser priority for emergency projects, those that focus on humanitarian aid, or those that are short-term rather than sustained development efforts.

Table 1.6 Typical System Constraints, Possible Disease/Service-specific and Health System Responses

Constraint	Disease or Service-Specific Response	Health System Response(s)
Financial inaccessibility (inability to pay formal or informal fees)	Exemptions/reduced prices for focal diseases	Development of risk pooling strategies
Physical inaccessibility	Outreach for focal diseases	Reconsideration of long-term plan for capital investment and siting of facilities. Coordination and joint planning with departments of transport and roads.
Inappropriately skilled staff	Continuous education/training to develop skills in focal diseases	Review of basic medical and nursing training curricula to ensure that appropriate skills are included in basic and in-service training.
Poorly motivated staff	Financial incentives to reward delivery of particular priority services	Institution of proper performance review systems, creating greater clarity of roles and expectations as well as consequences regarding performance. Review of salary structures and promotion procedures.
Weak planning and management	*Continuous education/training workshops to develop skills in planning and management*	Restructuring ministries of health. Recruitment and development of cadre of dedicated managers.
Lack of intersectoral action and partnership	*Creation of special disease-focused cross-sectoral committees and task forces at the national level*	Building systems of local government that incorporate representatives from health, education, and agriculture, and promote accountability of local governance structures to the people.
Poor quality care of care	Training providers in focus diseases or services	Development of monitoring, accreditation and regulation systems.

Source: Travis et al. (2004).

The overview in this chapter is intended to serve as a basic introduction to HSS issues. In-depth technical and contextual information is needed to apply many of the approaches presented here. Readers are encouraged to refer to the HSS technical assistance and tools cited in Annex 1D.

Bibliography

Asian Development Bank. 2004. *Project Completion Report on Cambodia Basic Health Services Project* (PCR CAM 27410). Manila: Asian Development Bank.

Atim, C., F. P. Diop, J. Etté, et al. 1998. *The Contribution of Mutual Health Organizations to Financing, Delivery and Access to Health Care in West and Central Africa: Summaries of Synthesis and Case Studies in Six Countries* (Technical Report No. 19). Bethesda, MD: Partnerships for Health Reform*plus* Project, Abt Associates Inc.

Axelsson, H., F. Bustreo, and A. Harding. 2003. *Private Sector Participation in Child Health, A Review of World Bank Projects, 1993–2002. Health, Nutrition, and Population Series.* Washington, DC: World Bank.

Barnum, H., J. Kutzin, and H. Saxenian. 1995. Incentives and Provider Payment Methods. *International Journal of Health Planning and Management* 10:23–45.

Bennett, S., A.Gamble Kelley, and B. Silvers. 2004. *21 Questions on Community-Based Health Financing.* Bethesda, MD: Partners for Health Reform*plus* Project, Abt Associates Inc.

Bennett, S., and E. Ngalande-Bande. 1994. *Public and Private Roles in Health: A Review and Analysis of Experience in Sub-Saharan Africa.* Geneva: World Health Organization, Division of Strengthening of Health Services.

Bertrand, W. E., B. E. Echols, and K. Husein. 1988. *Management Information Systems and Micro Computers in Primary Health Care.* Geneva: Aga Khan Foundation.

Brinkerhoff, D., and C. Leighton. 2002. *Decentralization and Health System Reform. Insights for Implementers.* Bethesda, MD: Partners for Health Reform*plus* Project, Abt Associates Inc.

Bryce, J., S. el Arifeen, G. Pariyo, C. F. Lanata, D. Gwatkin, J. Habicht, and the Multi-Country Evaluation of IMCI Study Group. 2003. Reducing Child Mortality: Can Public Health Deliver? *Lancet* 362:159–64.

Bustreo, F., A. Harding, and H. Axelsson. 2003. Can Developing Countries Achieve Adequate Improvements in Child Health outcomes without engaging the private sector? *World Health Bulletin* 81(12):886–94.

Butera, D. 2004. *Roles des Acteurs dans le Developpement des Mutuelles de Sante au Rwanda.* Paper presented at Forum de la Concertation. AWARE/USAID/WARP, November 17, Bamako, Mali.

De, S.,and I. Shehata. 2001. *Comparative Report of National Health Accounts Findings from Eight Countries in the Middle East and North Africa* (Technical Report). Bethesda, MD: Partnerships for Health Reform, Abt Associates, Inc.

De Savigny, D., H. Kasale, C. Mbuya, and G. Reid. 2004. *Fixing Health Systems.* Ottawa: International Development Research Center.

Donabedian, A. 1980. *Explorations in Quality Assessment and Monitoring*. Ann Arbor, MI: Health Administration Press.

Eisele et al. 2003. *Linking Health System Strengthening Interventions to the Strategic Objectives of USAID's Global Health Bureau, A Conceptual Framework* (draft). Partners for Health Reform*plus*.

Guldan, G. 1996.Obstacles to Community Health Promotion. *Social Science Medical Journal* 43:689–95.

Gwatkin, D. 2000. Health Inequalities and the Health of the Poor: What Do We Know? What Can We Do? *Bulletin of the World Health Organization* 78(1):3–15.

Hardeman, W., W. Van Damme, M. Van Pelt, et al. 2004. Access to Health Care for All? User Fees Plus a Health Equity Fund in Sotnikum, Cambodia. *Health Policy and Planning* 19(1):22–32.

Health Systems Action Network. 2006. Website. <http://www.hsanet.org/> (accessed Sept. 12, 2006).

John Snow, Inc. 2005. *Twelve Baseline Health Surveys.* Boston: John Snow, Inc. USAID-funded.

Joint Learning Initiative. 2004. *Human Resources for Health: Overcoming the Crisis*. Cambridge, MA: Harvard University Press.

Llewellyn-Jones, L. 2000. *Sharing Power: Principles for Community Participation in Health Promotion*. Rosebud, Australia: Australian Institute for Primary Care. <http://www.latrobe.edu.au/aipc/PDF%20Papers/Llewellyn-Jones_Lorraine_23.pdf> (accessed Sept. 12, 2006).

Liu, Xingzhu, D. R. Hotchkiss, S. Bose, et al. 2004. *Contracting for Primary Health Services: Evidence on Its Effects and Framework for Evaluation.* Bethesda, MD: Partners for Health Reformplus Project, Abt Associates Inc.

Marek, Tonia, I. Diallo, B. Ndiaye, and J. Rakotosalama. Successful Contracting of Prevention Services: Fighting Malnutrition in Senegal and Madagascar. *Health Policy and Planning* 14(4):382–89.

Mills, A., R. Brugha, K. Hanson, and B. McPake. 2002. What Can Be Done about the Private Health Sector in Low-Income Countries? *World Health Bulletin* 80(4):325–30.

Morris, S. 2004. Monetary Incentives in Primary Health Care and Effects on Use and Coverage of Preventive Health Care Interventions in Rural Honduras. *Lancet* 364:2030–37.

Normand, C. 1999. Using Social Health Insurance to Meet Policy Goals. *Social Science and Medicine* 48: 865–69.

Partners for Health Reform*plus.* 2005a. Child Survival Health Grantees Program (CSHGP) Partners' Meeting, January 19, 2005 (informal survey conducted by Partners for Health Reform*plus*), Bethesda, MD. Bethesda, MD: Partnerships for Health Reform, Abt Associates, Inc.

———. 2005b. *The Montreux Challenge: Making Health Systems Work* (draft). Bethesda, MD: PHR*plus*, Abt Associates, Inc.

———. n.d. *Using Community-Based Financing to Expand Access to Health Care. Issues and Results.* Bethesda, MD: Partners for Health Reform*plus* Project, Abt Associates Inc. <http://www.phrplus.org/Pubs/IR7.pdf> (accessed Sept. 12, 2006).

Project Concern. 2005. Municipal Health Partnership Program (MHPP) proposal, April 15, 2005.

Rondinelli, D. 1990. *Decentralizing Urban Development Programs: A Framework for Analyzing Policy* (CDIE Document No. PN-ABD-906). Washington DC: USAID, Office of Housing and Urban Programs.

Saunders, M. K. 2004. *Investments in Health Contribute to Economic Development.* Bethesda, MD: Partners for Health Reform*plus* Project, Abt Associates Inc.

Schieber, G., and M. Akiko. 1997. *A Curmudgeon's Guide to Financing Health Care in Developing Countries. Innovations in Health Care Financing* (World Bank Discussion Paper No. 365). Washington, DC: World Bank.

Schneider, P., and T. Dmytraczenko. 2003. *Improving Access to Maternal Health Care through Insurance. Insights for Implementers.* Bethesda, MD: Partners for Health Reform*plus* Project, Abt Associates Inc.

Schott, W., and M. Makinen. 2004. *Proposal for Mainstreaming Health Systems Initiative.* Bethesda, MD: Partners for Health Reform*plus* Project, Abt Associates Inc.

Schwartz, B., and I. Bhushan. 2004. Improving Immunization Equity through a Public Private Partnership in Cambodia. *Bulletin of the World Health Organization* 82(9), 661–67.

Smith, E., R. Brugha, and A. Zwi. 2001. *Working with Private Sector Providers for Better Health Care.* London: Options Consultancy Services Limited and London School of Hygiene and Tropical Medicine.

Soeters, R., and F. Griffiths. 2003. Improving Government Health Services through Contract Management: A Case from Cambodia. *Health Policy and Planning* 18(1):74–83.

Travis, P., S. Bennett, A. Haines, et al. 2004. Overcoming Health System Constraints to Achieve the Millennium Development Goals. *Lancet* 364(9437):900-06.

Waters, H., L. Hatt, and D. Peters. 2003. Working with the Private Sector for Child Health. *Health Policy and Planning* 18(2):127–37.

WHO (World Health Organization). 2000. The *World Health Report 2000. Health Systems: Improving Performance*. Geneva: WHO. <http://www.who.int/whr/2000/en/whr00_en.pdf> (accessed Sept. 12, 2006).

———. 2001. "What Is the WHO Health Systems Performance Framework?" WHO website. <http://www.who.int/health-systems-performance/concepts.htm> (accessed Sept. 12, 2006).

———. 2003. *Multi-Country Evaluation of IMCI Effectiveness, Cost and Impact (MCE). Progress Report, May 2002–April 2003.* Geneva: WHO.

———. 2006. *World Health Report 2006.* Geneva: WHO.

World Bank. 2004. *The Millennium Development Goals for Health, Rising to the Challenges.* Washington, DC: World Bank.

Wouters, A. 1998. *Alternative Provider Payment Methods: Incentives for Improving Health Care Delivery. Primer for Policymakers.* Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Zellner, S., B. O'Hanlon, and T. Chandani. 2005. *State of the Private Health Sector Wall Chart*. Bethesda, MD: Private Sector Partnerships-One (PSP-*One*) Project, Abt Associates Inc.

Annex 1A. Definition of Performance Criteria

Equity is a normative issue that refers to fairness in the allocation of resources or the treatment of outcomes among different individuals or groups. The two commonly used notions of equity are horizontal and vertical equity.

- **Horizontal equity** is commonly referred to as "equal treatment of equal need." For example, horizontal equity in access to health care means equal access for all individuals irrespective of factors such as location, ethnicity, or age.

- **Vertical equity** is concerned with the extent to which individuals with different characteristics should be treated differently. For example, the financing of health care through a social health insurance system may require that individuals with higher income pay a higher insurance contribution than individuals with lower income (similar to progressive taxation).

Efficiency refers to obtaining the best possible value for the resources used (or using the least resources to obtain a certain outcome). The two commonly used notions of efficiency are allocative and technical efficiency.

- **Allocative efficiency** means allocating resources in a way that ensures obtaining the maximum possible overall benefit. In other words, once allocative efficiency is reached, changing the allocation and making someone better-off without making someone else worse-off is impossible.

- **Technical efficiency** (also referred to as *productive efficiency*) means producing the maximum possible sustained output from a given set of inputs.

Access is a measure of the extent to which a population can reach the health services it needs. It relates to the presence (or absence) of economic, physical, cultural or other barriers that people might face in using health services. Several types of access are considered in the field of health care, but the two types that are primarily investigated in this assessment are financial access and physical access.

- **Financial access** (also referred to as *economic access*) measures the extent to which people are able to pay for health services. Financial barriers that reduce access are related to the cost of seeking and receiving health care, relative to the user's income.

- **Physical access** (also referred to as *geographic access*) measures the extent to which health services are available and reachable. For example, not having a health facility within a reasonable distance to a village is physical access barrier to health care for those living in the village.

Quality is the characteristic of a product or service that bears on its ability to satisfy stated or implied needs. Quality is defined as "that kind of care which is expected to maximize an inclusive measure of patients' welfare after one has taken account of the balance of expected

gains and losses that attend the process of care in all of its parts" (Eisele and others 2003, citing Donabedian 1980).

Sustainability is the capacity of the system to continue its normal activities well into the future. The two commonly used notions of sustainability are financial and institutional sustainability.

- **Financial sustainability** is the capacity of the health system to maintain an adequate level of funding to continue its activities (for example, ability to replace donor funds from other sources after foreign assistance is withdrawn).

- **Institutional sustainability** refers to the capacity of the system, if suitably financed, to assemble and manage the necessary nonfinancial resources to successfully carry on its normal activities in the future.

Annex 1B. Examples of How Selected HSS Interventions Have Influenced the Use of Priority Services

Examples of Successful HSS Interventions	Description of Intervention	Positive (▲) or Negative (▼) Effect on Health System Performance	Outcomes in Terms of Service Use or Health Impact
Contracting of private health care service management: Pereang District Cambodia (Soeters and Griffiths 2003) This example addresses all services	Contracting with an international NGO to manage a network of district health facilities from 1999 to 2003	▲ Access to health services increased, even with official user fees, because the fees were less than the "informal" user fees demanded from government-managed facilities. Out-of-pocket household expenditures decreased. ▲ Quality was shown to improve as a result of performance-based incentives. ▼ Equity may have been compromised because the poor were not given user fee exemptions. ▼ Informal private activities to earn extra income by privately contracted managers may have negatively affected quality and efficiency.	Use of basic health services increased dramatically among the privately managed facilities. The increases in use were primarily attributed to improved quality and financial access.
Example of social insurance in Bolivia (Schneider and Dmytraczenko 2003) This example focuses on maternal and child health services but may also be applicable to other services.	SNMN (Spanish acronym for National Insurance for Mothers and Children) was implemented in 1996. The plan reduced out-of-pocket expenditures and covered a range of maternal and child health services. The intervention was implemented in the midst of a decentralization initiative.	▲ Access was shown to increase as a result of decreased financial barriers. ▼ Sustainability was an issue because reimbursement rates did not meet actual facility expenditures. ▼ Inefficiency was also an issue as patients sought care in higher level facilities (no co-payments).	Use of formal maternal and child health services increased as a result of the insurance scheme, but use by the poorest groups increased less than by other groups.

Examples of Successful HSS Interventions	Description of Intervention	Positive (▲) or Negative (▼) Effect on Health System Performance	Outcomes in Terms of Service Use or Health Impact
Tanzania Essential Health Interventions Project (TEHIP) (De Savigny and others 2004)	The TEHIP's primary aim was to test the Word Bank's *World Development Report 1993* suggestion that health can be significantly improved by adopting a minimum package of health interventions to respond directly and cost-effectively to evidence about the burden of disease. Incremental, decentralized, sector-wide health basket funding and a tool kit of practical management, planning, and priority-setting tools to facilitate evidence-based district level decision making were introduced to accomplish the above.	▲ Efficiency (allocative) and equity: the introduction of TEHIP tools significantly improved budget allocation directing resources to high priority, cost-effective interventions, some of which had previously been underfunded. ▲ Efficiency (technical): Stronger planning, management, and administration at the district level from tools for decision making. ▲ Quality: District managers' adoption of IMCI improved quality of child health services and capacity of health workers. Possible increased adult patient attendance at facilities for IMCI may also benefit from worker capacity.	Child mortality in the two districts fell by over 40 percent in the five years following the introduction of evidence-based planning; and death rates for men and women between 15 and 60 years old declined by 18 percent.
Monetary incentives in primary health care and effects on use and coverage of preventive health care interventions in rural Honduras (Morris 2004) This example focuses on maternal and child health services.	In this cluster-randomized trial, municipalities of high malnutrition prevalence were selected with the objective of increasing demand for preventive health care in pregnant women, new mothers, and children under three years by— Using conditional payments to households (the household-level package) Improving quality of peripheral services by providing resources and training (service-level package) The baseline survey was conducted in 2000, with a follow-up in 2002.	▲ Access to services increased through decreased financial barriers. ▼ Efficiency and quality: Transferring resources to local health teams proved legally and logistically difficult and could not be properly implemented, even though quality training was given. No significant impact could be attributed to the service package alone, possibly in part because of the partial implementation of this service package. The difficulty of this transfer of resources is cited as a finding itself. ▼ Sustainability: Questions remain about the long-term sustainability of cash transfer programs, enforcement of conditionality vouchers, or both.	This intervention had a large impact on coverage of prenatal care and well-child checkups (18–20 percentage points each), specifically from the conditional payment package. Increased frequency of contact facilitated timely immunization series initiation for children; however, measles coverage and tetanus toxoid for mothers were not affected.

Source: Partners for Health Reformplus (2005)

Annex 1C. Summary of Private Sector Interventions

Intervention	Description	Expected Results	Additional Sources of Information
Social marketing	Social marketing is the use of commercial marketing techniques to achieve a social objective. In developing countries, donors have used social marketing to increase access and use of products such as contraceptives, oral rehydration salts, and insecticide-treated nets.	Social marketing is a well-established and proven strategy for increasing access and use of essential health products.	Armand, F. 2003. *Social Marketing Models for Product-Based Reproductive Health Programs: A Comparative Analysis*. Washington DC: USAID/Commercial Market Strategies Project. Kikumbih, N., K. Hanson, A. Mills, et al. 2005 The Economics of Social Marketing, The Case of Mosquito Nets in Tanzania. *Social Science and Medicine* 60: 269–381. Chapman, Steve, and H. Astatke. 2003. *The Social Marketing Evidence Base: A Review of 87 Research Studies*. Washington, DC: PSI, 2003.
Vouchers	Vouchers have been used to subsidize the price of health services and products to target populations with the goal of improving access to and use of those services and products.	Vouchers increase consumer choice and affordability of care from private sector providers through subsidy of goods or services. Developing countries have only recently begun experimenting with voucher programs for health products and services.	Islam, Mursaleena. 2006. *Primer for Policymakers—Vouchers for Health: A Focus on Reproductive Health and Family Planning Services.* Bethesda, MD: PSP-One/PHRplus, Abt Associates Inc. Sandiford, Peter, A. Gorter, and M. Salvetto. 2002.*Vouchers for Health: Using Voucher Schemes for Output-Based AID*. (Public Policy for the Private Sector, Viewpoint, No. 243.) Washington DC: World Bank. World Bank. 2005. *A Guide to Competitive Vouchers in Health*. Washington, DC: The World Bank, 2005
Contracting out	Governments contract with private providers (both not-for-profit and for-profit) to deliver individual or a bundles of health services.	Contracting out expands private sector coverage of particular services via government finance and may (through contract specification) improve quality of care. Sometimes, contracting out is said to improve efficiency and quality through competition.	Loevinsohn, Benjamin, and A. Harding. 2004. *Buying Results: A Review of Developing Country Experience with Contracting for Health Service Delivery*. Washington, DC: World Bank. Liu, Xingzhu, D. Hotchkiss, S. Bose, et al. 2004. *Contracting for Primary Health Services: Evidence on Its Effects and a Framework for Evaluation*. Bethesda, MD: PHR*plus.*

Intervention	Description	Expected Results	Additional Sources of Information
Public–private partnerships	Private companies join with government, international organizations, or nonprofits to focus on addressing a social need.	Such partnerships leverage private sector resources for the delivery of health products and services.	Marek, Tonia, C. O'Farrell, C. Yamamoto, and I. Zable. 2005. *Trends and Opportunities in Public-Private Partnerships to Improve Health Service Delivery in Africa*. Washington, DC: World Bank. Rionda, Zynia L. 2002. *A Compendium of Corporate Social Responsibility Activities Worldwide*. Washington DC: USAID/Catalyst Consortium. *Building on the Monterrey Consensus: The Growing Role of Public-Private Partnerships in Mobilizing Resources for Development*. Cologne/Geneva: World Economic Forum, 2005. PSI. 2005. *Corporate AIDS Prevention Programs: Fighting HIV/AIDS in the Workplace*. Washington, DC: PSI.
Provider networks and franchises	Networks and franchises are an affiliation of health services providers grouped together under an umbrella structure or parent organization.	Networking providers has been found to be effective to ensure a standard of quality and price for given services. It also allows for the scale-up of services through individual private providers.	Chandani, Taara, S. Sulzbach and M. Forzley. 2006. *Private Provider Networks: The role of Viability in Expanding the Supply of Reproductive Health and Family Planning Services*. Bethesda, MD: Bethesda, MD: Private Sector Partnerships-One (PSP-*One*) Project, Abt Associates Inc. Montagu, Dominic. 2002. *Franchising of Health Services in Developing Countries*, Health Policy and Planning, 17(2):121-130. Cambridge: Oxford University Press. Tsui, Amy. 2005. *Franchising Reproductive Health Services: What can the private health sector in Three Developing Countries Contribute?* Public Health Grand Rounds Lecture. Baltimore, MD: Johns Hopkins University Bloomberg School of Public Health, Jan. 26, 2005.

Intervention	Description	Expected Results	Additional Sources of Information
Accreditation	Assessment of a health care organization or a private provider's compliance with a pre-established performance standard.	Accreditation is a strategy for improving the performance of providers against a pre-established quality standard.	Heerey, Michelle, and Edgar Necochea. 2005. *An Overview of Accreditation and Certification for Improving Health Service Quality*. Baltimore, MD: JHU-CCP. World Health Organization. 2005. *Accreditation in Healthcare Services—A Global Review*, Washington, DC: WHO.
Policy reform	The laws, policies, regulations, and procedures that affect the environment for private sector provision of health services can be changed. These policies range from laws that restrict private providers to lack of appropriate policy oversight of the private sector by government.	Policy reform increases private sector participation by removing unnecessary policy obstacles to private sector participation.	Ravenholt, B., R. Feeley, D. Averbug, and B. O'Hanlon. 2006. *Navigating Uncharted Waters: A Guide to the Legal and Regulatory Environment for FP Services in the Private Sector*. Bethesda, MD: Private Sector Partnerships-One (PSP-*One*) Project, Abt Associates Inc. *PHRplus.* 2.1. *Working with Private Providers to Improve the Delivery of Priority Health Services*. Bethesda, MD: PHR*plus*. Marek, Tonia, C. O'Farrell, C. Yamamoto and I. Zable. 2005.*Trends and Opportunities in Public-Private Partnerships to Improve Health Service Delivery in Africa*. Washington, DC: World Bank.
Training, continuous education for private providers	Knowledge and skills of private providers are improved through a variety of training techniques including direct training, continuous medical education, and detailing.	Training improves knowledge, skill, and quality of care of private providers.	Smith, E., R. Brugha, and A. Zwi. 2001. *Working with Private Sector Providers for Better Health Care: An Introductory Guide*. London: Options and LSHTM.

Annex 1D. HSS Technical Assistance and Tools

Systems Strengthening Area	Assessment and Improvement Technical Assistance and Tools
HSS diagnostics	• Tools and methods for diagnosing the sources of system weakness (in financing, policy, organization and management, resource allocation, quality, and commodities)
Financing	• Financing policy development • Cost analysis • Basic accounting tools • National health accounts • Tools for community-based insurance and pre-payment schemes • Insurance development (national, social) including actuarial tools • Financial sustainability plans
Policy	• Stakeholder analysis • Political mapping • Equity analysis techniques • Policy analysis methods • Advocacy tools • Public and private sector relationship • Regulation
Organization and management	• Efficiency assessment • Health and financial management information systems (national, regional, district, and facility) • Accreditation guidelines • Health worker motivation • Health facility organization and productivity • Contracting with public and private providers
Resource allocation	• Resource planning models • Resource requirements projection tools • Provider payment methods • Cost-effectiveness analysis
Subsector-specific tools (HIV/AIDS)	• National health accounts subanalysis • Financing and Subsidy Strategy Development Tool • AIDSTreatCost (ATC) model • GOALS computer model for funding allocation • Workplace quality model
Commodities management	• Medicines and supplies policy • Inventory management tools • Demand forecasting models • Ordering and dispatching tools
Quality assurance	• Quality thesaurus • Provider self-assessment tools • Patient exit interviews • Tools for supervision for quality

Source: Schott and Makinen (2004)